

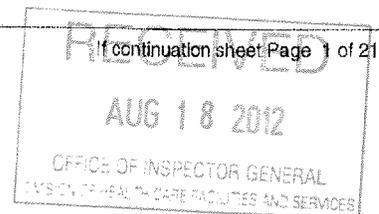
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2012
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Brownsboro Hills Health Care acknowledges receipt of the statement of deficiencies and the plan of correction does not constitute any admission that any deficiencies are accurate. The plan of correction is submitted as a written allegation of compliance.	
F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy, it was determined the facility failed to provide a clean, comfortable, and homelike environment for two (2) of the eighteen (18) sampled residents (#4 and #14), three (3) of the sixty-one (61) resident rooms, and one (1) of the two (2) dining rooms.</p> <p>The findings include: Record review of the facility's policy regarding Maintenance, dated 03/12, revealed the facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need</p>	F 252	<p>F 252 It is the policy of this facility to be in compliance with this regulation.</p> <p>1. Resident #4's window blind was replaced.</p> <p>Resident 14's has window blinds in place.</p> <p>Rooms E7, B8, and B10 have window blinds in place.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *J. J. Stahle* TITLE Administrator 8/18/12 (X6) DATE

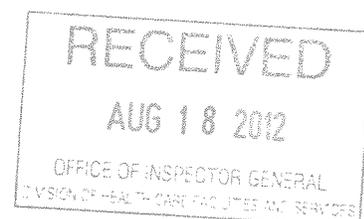
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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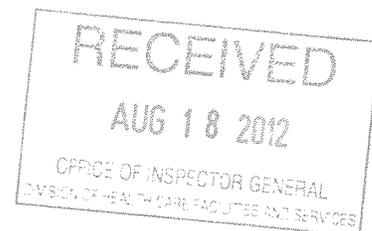
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F 252	<p>Continued From page 1</p> <p>of repair. The director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form. Environmental Services personnel will check for completed forms throughout the day.</p> <p>Observation, on 07/10/12 at 8:10 AM, during tour revealed Resident #4's window blind had multiple broken slates hanging free. The blind remained broken until the survey team exited from the facility.</p> <p>Observation of Resident #14's room, on 07/10/12 at 9:00 AM, revealed the room did not have a window treatment/curtain.</p> <p>Observation during facility tour, on 07/10/12 at 9:15 AM, revealed rooms E-7, B-8, and B-10 did not have a window treatment/curtain. Room B-8 had a clock flashing 12:00 and turned facing away from the resident lying in the bed.</p> <p>Observation, on 07/10/12 at 12:25 PM, during lunch observation in the Bistro/Multi dining rooms revealed bare white walls and partial white window treatments/curtains covering only half of each window.</p> <p>Interview with resident #14, on 7/10/12 at 10:00 AM, revealed the resident thought it would be nice if something was on the window to make it more homelike.</p> <p>interview with the Maintenance Director, on 07/12/12 at 3:05 PM, revealed the broken window blind not only looked bad, but made the facility</p>	F 252	<p>Room B8's clock has been re-set and is now facing the resident.</p> <p>Wall decorations have been placed in the Bistro.</p> <p>2. A room to room audit was completed by the housekeeping Supervisor on 8/1/2012 and 8/3/2012 to identify further concerns with blinds/homelike environment and corrections made as needed.</p> <p>3. The maintenance request process has been revised to include a binder being placed at each nurse's station with maintenance request forms to be completed by staff and left in the binder for the maintenance staff to review each week day and to repair/correct issues. Completed requests are signed and left in the</p>	



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F 252	Continued From page 2 appear as though it did not fix broken items. The Maintenance Director revealed the lack of window treatments/curtains did not make the facility appear homelike.	F 252	binder for future reference. A copy of the on call schedule is also included in the binder. The maintenance director inserviced the staff on 7/20/12 on how to report concerns with blinds and other issues related to a homelike environment and will re-inservice staff on 8/17/12 on the process. The Housekeeping Supervisor was re-educated by the District Housekeeping Director on 7/16/12. Housekeeping staff was re-educated by the Housekeeping Director on 7/26/12 and 8/2/12 on proper cleaning of facility and in reporting concerns to the maintenance department via the new process.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies General Hospitality Services, and Maintenance, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for two (2) of the eighteen (18) sampled residents, Residents #4 and #14, five (5) of sixty-one (61) resident rooms, one (1) of one (1) shower room, and a resident sitting area.  The findings include:  Record review of the facility's policy regarding	F 253	Each resident room has window blinds to maintain privacy. In order to ensure a clean environment is	

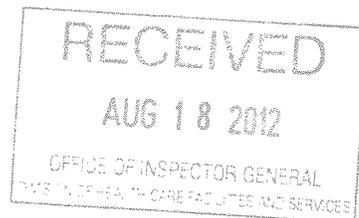


F 252 Continued

maintained by having a cleanable surface, the window curtains and rods will be removed from all resident rooms. The areas will be repaired and the frames painted in an accent color to provide a homelike environment.

The maintenance director and the housekeeping supervisor were reeducated by the administrator on 7/27/12 on the use of the QA tool that will be used to detect items that need to be cleaned, replaced or repaired. The Housekeeping Supervisor was trained by the District Housekeeping Director and the Administrator on 8/10/12 on a new daily audit tool.

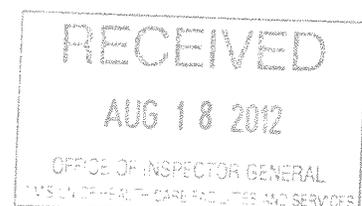
4. The Housekeeping Supervisor will complete room to room audits 3 X per week times 4 weeks and then weekly x 4 weeks and then monthly. The District Housekeeping Director will complete the room audit weekly x 4 weeks, then monthly x 3 months. During the audit process, immediate education will be provided to the housekeeping staff as issues are identified and corrected. Coaching and counseling will occur as needed. When completed, audits results will be given



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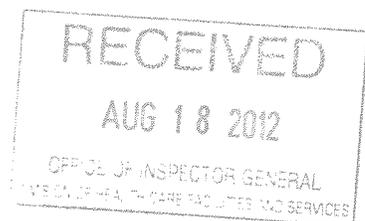
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F 253	Continued From page 3 General Hospitality Services Policies, dated 03/12, revealed the facility was to provide a clean, contamination-free surroundings for residents, visitors and personnel. A clean environment is essential in prevention/transmission of infection in the facility. Resident Rooms: routine cleaning is to be done on a daily basis; floors are to be dust mopped, then wet mopped daily with a disinfectant solution; dusting of furniture is to be done every day; mop water is to be changed when it is dirty (at least every three rooms); and wastebaskets are to be emptied daily, wiped with a disinfectant, and plastic liners replaced. Bathrooms: handwashing facilities are to be cleaned daily; bowls are to be cleaned daily with a germicidal disinfectant; and bathroom tubs, tile, and shower stalls are to be cleaned daily with a germicidal disinfectant spray. Trash and waste are to be removed from the building several times per day and placed in dumpsters located outside of the building.  Record review of the facility's policy regarding Maintenance, dated 03/12, revealed the facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. The director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form. Environmental Services personnel will check for completed forms throughout the day.  Observations during the initial tour, on 07/10/12 at 8:15 AM, revealed the following:	F 253	to the Administrator for review, tracking and trending Further coaching and counseling will occur as needed. Results of the audits will be reviewed at the monthly QA meeting to ensure a safe, clean, comfortable homelike environment.  F253 It is the policy of this facility to be in compliance with this regulation.  1. All mattresses in A Hall and B Hall rooms were cleaned and disinfected. The carpet was cleaned with odor ban and a deodorizer was used on A Hall.  Room A7-2 the soiled blanket was removed, the mattress disinfected and a clean blanket was placed on the bed.	F252 8/24/12	



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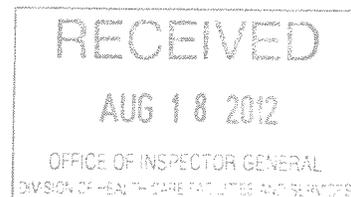
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F 253	Continued From page 4  1. Strong pervasive urine odors were noted in the A hallway.  2. Room A7-2, the resident's bed was covered with a white blanket with a large dry dark yellow area, a urinal half full of dark urine was placed on a three drawer table between the window and the bed and the room had a strong smell of urine.  3. Resident #4's shared bathroom had a strong smell of urine with a urine soaked adult brief observed on the tile floor between the toilet and the wall.  4. The toilet in room A-8 contained a large amount of foul smelling brown substance.  5. Room A8-1 revealed the bed had a missing bed post on the headboard with the broken post located under the bed up against the wall.  6. Room C-6 had an overhead light which did not work.  7. Room D6 had a privacy curtain hanging between bed 1 and 2 with a large dark brown colored stain. The bathroom had 3 large areas of sticky dried yellow substance on the floor and a pervasive urine odor was noted.  8. Room D1 had no overbed light cord.  9. The sitting area between B and D hallway had a window, at floor level, opened outward with no screen. A towel saturated with a brown colored substance was under the air conditioning unit. A brown sticky substance was on the coffee table.	F 253	Resident #4 – the soiled brief was bagged and removed from the room and the bathroom was cleaned by housekeeping.  Room 8 – the toilet was cleaned and the bed post was reattached to bed A8-1.  Room C6 – the overbed light was repaired.  Room D6 – the privacy curtain was replaced and the bathroom cleaned.  Room D1 – the overbed light cord has been replaced.  B/D Hall window has been repaired and the area has been thoroughly cleaned.  A7-2 the soiled blanket was removed and replaced with a clean blanket.  D Hall shower room – has been thoroughly cleaned and a screen placed in the	



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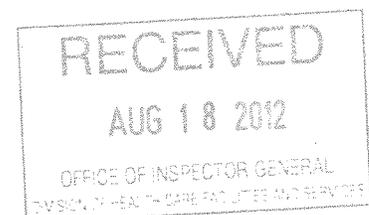
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F 253	Continued From page 5  Observation, on 07/11/12 at 8:00 AM, revealed room A7-2 resident's bed with a large dry yellow spot on the white blanket. Pervasive urine odors noted.  Observation of the D hall shower room, on 07/12/12 at 2:45 PM, revealed a window in the toilet room was open, with no screen, and a tree limb and leaves were coming through the window. Spider webs with trapped insects was noted around the window. Four (4) large areas of chipped out tile on the floor, leaving large divots with pooled water on the floor.  Interview, on 07/10/12 at 8:45 AM, with MDS Coordinator #3 revealed she was surprised to see the urine soaked brief on Resident #4's shared bathroom floor. MDS coordinator #3 further stated this was not the facility standard and the risks associated with the soiled brief being placed on the floor included infection control, fall hazards, and odor control.  Interview, on 07/10/12 at 8:50 PM, with MDS Coordinator #3 revealed the smell in room A7 was a little strong. She further stated housekeeping needed to change the bed linens.  Interview with Resident #4's family member, on 07/12/12 at 12:10 PM, revealed on weekends the resident's room had a strong odor of urine.  Interview with Licensed Practical Nurse (LPN) #2, on 07/10/12 at 8:15 AM, revealed the A hallway did have a urine odor. Continued interview with LPN #2, on 07/10/12 at 9:00 AM revealed room D6 had dried urine on the floor. The LPN	F 253	<p>window. The floor in the shower room will be repaired/replaced by 8/24/12.</p> <p>2. A room to room audit was completed by the Housekeeping Supervisor on 8/1/12 and 8/3/12 to identify further concerns with privacy curtains being clean. The Housekeeping Supervisor conducted an additional room to room audit and an audit of common areas on 8/13/12 to identify further concerns with odors, toilets being cleaned and the overall cleanliness of the facility. The maintenance staff will conduct a room by room audit to assist in identifying and repairing concerns with overhead lights, broken beds and other maintenance issues by 8/23/12.</p> <p>3. The maintenance request process has been revised to include a binder being placed at each nurse's station with maintenance request forms</p>	



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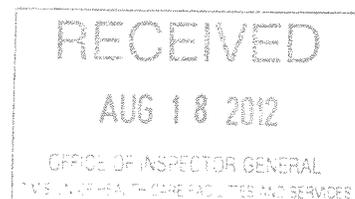
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F 253	Continued From page 6 revealed housekeeping was an ongoing problem.	F 253	to be completed by staff and left in the binder for the maintenance staff to review each week day and to repair/correct issues. Completed requests are signed and left in the binder for future reference. A copy of the on call schedule is also included in the binder. The maintenance director inserviced the staff on 7/20/12 on how to report concerns with blinds and other issues related to a homelike environment and will re-inservice staff on 8/17/12 on the process. The Housekeeping Supervisor was re-educated by the District Housekeeping Director on 7/16/12. Housekeeping staff was re-educated by the Housekeeping Director on 7/26/12 and 8/2/12 on proper cleaning of facility and in reporting concerns to the maintenance department via the new process.		
	<p>Observation of room D6, on 07/10/12 at 11:25 AM and 1:30 PM, revealed the bathroom still had dried urine on the floor, as identified by LPN #2.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 07/12/12 at 2:25 PM, revealed the bed in A7-2 was not changed until late in the afternoon. CNA #3 revealed she identified the linens needed to be changed due to the lingering urine odor. CNA #3 also revealed she did not know the linens were soiled, although she revealed she was aware the resident was known to spill urine on his/her bed.</p> <p>Interview with Resident #14, on 07/10/12 at 11:25 AM, revealed the resident had frequent problems with getting his/her room cleaned. Resident #14 stated he/she was going to report ants in the room and hoped someone would come in to clean.</p> <p>Interview with the Housekeeping Manager, on 07/12/12 at 3:05 PM, revealed he had been using an odor eliminator in the halls to cover the urine odor. The Housekeeping Manager revealed he went through each room on a regular basis to see if there were problems. The Housekeeping Manager revealed he had seen where things could be done better. The Housekeeping Manager revealed each housekeeper utilized the Daily Game Plan tool which had a section for housekeeping to write maintenance concerns to be reported. However, review of the tool revealed none of the above items were noted.</p> <p>Interview with the Assistant Director of Nursing</p>				



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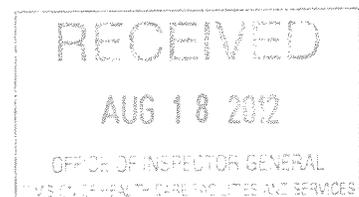
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F 253	Continued From page 7 (ADON), on 07/12/12 at 3:05 PM, revealed the nursing department should be reporting concerns, removing soiled linens, flushing toilets, and disposing of soiled briefs appropriately.	F 253	The maintenance director and the housekeeping supervisor have been reeducated by the administrator on 7/27/12 on the use of the QA tool that will be used to detect items that need to be cleaned, replaced or repaired. The Housekeeping Supervisor was trained by the District Housekeeping Director and the Administrator on 8/10/12 on a new daily audit tool.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies Identification of At Risk and Suggested Interventions, and Skin Care and Wound Management, it was determined the facility failed to provide appropriate nursing care to one (1) of the eighteen (18) sampled residents (Resident #5) assessed and identified by the facility as being at	F 282	Mock survey rounds will be conducted each week day by the management team to aid in identifying areas of concern and the correction of issues.  4. Mock survey rounds results will be discussed with the management team each weekday. The Housekeeping Supervisor will complete room to room audits 3 X per week X 4 weeks and then	



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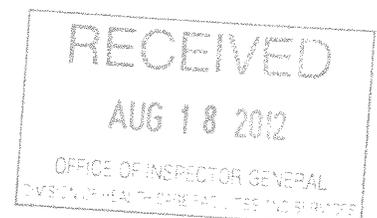
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F 282	Continued From page 8 risk for the development of pressure ulcers.	F 282	weekly x 4 weeks and then monthly. The District Housekeeping Director will complete the room audit weekly x 4 weeks, then monthly x 3 months. During the audit process, immediate education will be provided to the housekeeping staff as issues are identified. Coaching and counseling will occur as needed. When completed, audits results will be given to the Administrator for review, tracking, trending and follow up as needed. Further coaching and counseling will occur as needed. Results of the audits will be reviewed at the monthly QA meeting to ensure a safe, clean, comfortable homelike environment.	F253 8/24/12
	<p>The findings include:</p> <p>Review of the facility's policy Identification of At Risk and Suggested Interventions, dated 03/2012, revealed when a skin assessment identifies an individual as at risk, there are certain interventions which should be done to reduce the risk: cleansing must be done at the time of soiling and at other intervals conducive to good hygiene; and reduce pressure by using a turning/reposition program for those residents confined to bed/chairs.</p> <p>Review of the facility's policy Skin Care and Wound Management, dated 08/2010, revealed daily rounds should be conducted to verify frequent redistribution off areas of pressure, toileting schedules are followed, and assistance with nutrition and fluid intake is occurring.</p> <p>Review of Resident #5's clinical record revealed the facility assessed the resident on 07/02/12 as being high risk, with a score of eleven (11), utilizing the Braden Scale for predicting pressure sore risk. Review of the Minimum Data Set (MDS), dated 07/03/12, revealed the facility assessed the resident as requiring extensive assistance with bed mobility, total dependence for transfers, extensive assistance with toileting and eating, always Incontinent of bowel and bladder, at risk for developing a pressure ulcer and rare speech clarity.</p> <p>Review of Resident #5's plan of care revealed interventions for nursing staff to assist with turning and repositioning, and to check for</p>			



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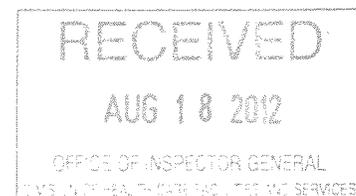
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NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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F 282	<p>Continued From page 9</p> <p>incontinent episodes and provide peri-care as needed.—Review of the Certified Nursing Assistance (CNA) Resident Profile Report revealed the resident was total care for all activities of daily living. Review of the communication board, located at the nursing station, revealed Resident #5 was identified as a Early Riser and was to be transported to the therapy gym by the third shift.</p> <p>Continuous observation of Resident #5, on 07/12/12 from 8:45 AM to 12:25 PM, revealed the resident was sitting up in a wheelchair in the B hall sitting area parked against a wall. At 10:04 AM, the resident was transported buy a CNA to the Main Dining Room for morning exercise. Range of motion was performed to the upper extremities only. At 11:30 AM, the resident was transferred back to the B hall sitting area and parked against the wall. During observation, no attempts were made by the resident to reposition self. Throughout the entire observation the resident was not off loaded/ repositioned, offered fluids or nutrition, checked for incontinent episodes, or provided with perineal/ incontinent care by the facility staff. At 12:25 PM the surveyor requested the nursing staff to assist the resident to his/her room and observation revealed the resident's brief was heavily saturated with dark yellow liquid.</p> <p>Interview with CNA #1, on 07/12/12 at 12:25 PM, revealed the resident had last been checked for incontinence and provided with perineal care before therapy, which was prior to breakfast. The CNA revealed residents should be checked every two (2) hours to prevent skin breakdown. The CNA revealed an extended amount of time had</p>	F 282	<p>F282</p> <p>1. Resident #5 was reassessed on 7/30/12 to determine if he/she remained high risk for skin breakdown and that current plan of care was applicable. Upon reassessment it was determined that this resident remains at high risk for skin breakdown and current plan of care is appropriate. Nursing staff was re-educated by the ADCS on 7/30/12 on following the resident's plan of care with regards to decreasing his risk of skin breakdown and the development of pressure ulcers.</p> <p>C.N.A. #1, L.P.N. #4 and RN Unit Manager were re-educated by the ADCS on 7/30/12 regarding following Resident #5's plan of care and identified issues that must be corrected.</p>		



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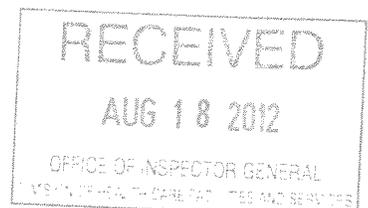
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F 282	Continued From page 10 passed and the resident should have been checked.  Interview with Licensed Practical Nurse (LPN) #4, on 07/12/12 at 2:30 PM, revealed Resident #5 was total care and should be checked and repositioned at least every two (2) hours to prevent the development of pressure areas. The LPN was not aware the resident had not been provided care. The LPN revealed nursing was responsible to ensure required care was being provided.  Interview with the Unit Manager (UM), on 07/12/12 at 3:55 PM, revealed not providing appropriate nursing care was unacceptable. The UM revealed the resident was a high pressure risk and should be checked every two (2) hours. The UM revealed she was responsible to follow up with nurses and watching the CNA's to ensure care was provided. The UM revealed education was provided to both CNAs and nurses on skin care.  Interview with the Director of Nursing (DON), on 07/12/12 at 4:20 PM, revealed the facility did not have a policy specifying every two (2) hours for positioning of residents at high risk for pressure development, but that care should be individualized. The DON revealed she expected the staff to check Resident #5 at least every two (2) hours based on the assessment and the needs of the resident. The DON revealed there was a potential for skin breakdown for Resident #5 and she stated she was responsible to ensure nursing services were provided appropriate nursing care.	F 282	Skin Assessment was performed on Resident #5 by LPN #4 (with surveyor observation) on 7/12/12 and there were no negative findings.  2. Resident's assessed as being high risk for skin breakdown had the potential to be affected by this practice.  100% of current residents will be reassessed by the RN Unit Manager utilizing the Braden Scale for predicting pressure ulcer risk by 8/10/12.  100% of current residents will have care plan reviewed by the IDCPT to assure current interventions are applicable as compared to current Braden Scale Pressure Ulcer risk by 8/10/12.	



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F 282	Continued From page 11 Interview with the Assistant Director of Nursing (ADON), on 07/12/12 at 5:30 PM, revealed both nurses and CNAs are educated annually on skin care and prevention of pressure ulcers. However, the ADON was not able to produced evidence that CNA #1 had received the education.	F 282	3. Nursing Staff will be re-educated by the ADCS by 8/10/12 on the following:	
F 372 SS=F	<b>483.35(l)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY</b>  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy General Hospitality Services, it was determined the facility failed to properly dispose of refuse and garbage to prevent the harborage of pests and rodents for one (1) of one (1) dumpster on the facility grounds.  The findings include:  Review of the facility's policy General Hospitality Service, dated 03/2012, revealed trash and waste are to be removed from the building several times per day and placed in dumpsters located outside of the building.  Observation of the facility, on 07/10/12 at 4:00 PM, revealed the side yard of the facility grounds, along the D hallway, with multiple piles of wood planks, soda cans, beer cans, a cracked bucket, a large blue bowl, candy wrappers and paper.  Observation of the facility grounds behind the	F 372	* Following Resident Care Plan * Providing appropriate nursing care to residents identified as High Risk Skin Breakdown * Supervision of C.N.A's to assure delivery of care provided per individualized plan of care  LPN #4 and RN Unit Manager were in attendance at the inservice on 8/10/12.  Rounds will consist of observing each resident identified as at high risk for development of pressure ulcers. The residents will be observed to determine (a) good hygiene (b) pressure reduction by turning and repositioning (c) toileting schedules are followed as indicated (d) resident is assisted with nutrition and fluid intake (e) incontinence care as indicated.	



F282 Continued

QI monitoring rounds will be conducted 2 times daily on each shift on each unit by the RN Unit Manager &/or House Supervisor to ensure staff are providing services in accordance with each resident's plan or care.

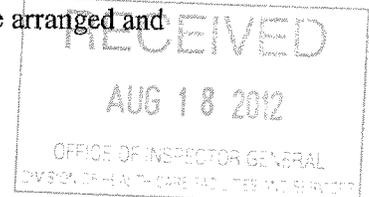
Any issues identified during the time of the QI monitoring round will be addressed at that time to include coaching and re-education if indicated.

Rounding with this new tool will begin by ~~8/24/13~~. Any noted areas of concern will be immediately addressed and reported to the DCS or ADCS. The Rounding Tool will be reviewed during Morning Meeting, Monday - Friday, to address any identified issues and/or continued educational needs of the staff.

*8-24/12  
per Jane Stahl  
by PG 8-22/12*

The ADCS will QI Monitor (audit tools) starting 8/13/12 to assure licensed nurses and unit managers are supervising the delivery of care to the residents according to their individualized plan of care. QI audits will have random sample of 10% of the residents identified at risk on each unit weekly x 4 weeks, then monthly.

4. The Administrator will QI monitor the ADCS tools weekly x 4 weeks then monthly to ensure that services are arranged and



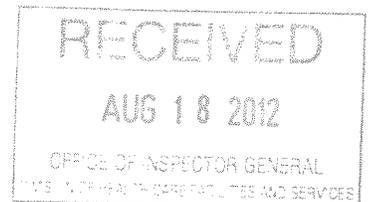
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F282 Continued

provided by qualified persons  
in accordance with residents  
written plan of care.

QI audits will be reviewed in  
the monthly QA meeting to  
ensure that services provided  
or arranged by the facility are  
provided by qualified persons  
in accordance with each  
resident's written plan of  
care.

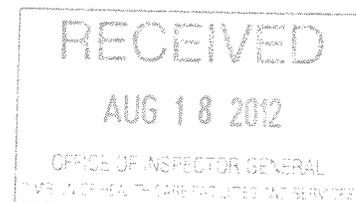
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F 372	Continued From page 12 dumpster along the C hallway, on 07/12/12 at 2:00 PM, revealed a partially fenced area with a blue crate filled with empty soda cans sitting on the ground. A large gray garbage can, without a lid, filled with soda cans, candy wrappers, hair nets, and bags was parked by the fence. Laying on the ground next to the garbage can were candy wrappers, a lawn sprinkler, an empty cigarette pack, two (2) boxes of surface source floor tile with weather eroded packaging, and a plastic container half filled with an orange liquid. A motor with fan blades covered with a orange roughly textured substance was sitting on the ground. The side door of the dumpster was opened exposing the garbage inside. A wood pallet was lying on the ground behind the dumpster.	F 372	F 372 It is the policy of this facility to be in compliance with this regulation.  1. Grounds along the D Hallway belonging to the apartment complex behind the facility were cleared of debris.  The maintenance area located outside the maintenance office behind the privacy fence was cleared of debris including removal of the crate with cans, placing a lid on the trash can, wrappers, sprinkler, tile and a motor fan blade. The side door of the dumpster was closed and the wooden pallet removed.	
F 441 SS=F	Interview with the Maintenance Director, on 07/12/12 at 2:00 PM, revealed the motor on the ground did not work. The Maintenance Director revealed he was not aware he could not store garbage in the partially fenced area. The Maintenance Director revealed the area could be visible by residents from resident rooms and could potentially harbor pests and rodents. Continued interview with the Maintenance Director on 07/12/12 at 3:05 PM, revealed the side yard by D hall did look bad and could potentially harbor pests and rodents. The Maintenance Director revealed he was not aware of what was considered the facility's property. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	2. An external audit of the grounds will be completed by the director of maintenance by 8/3/12 to identify other opportunities for improvement.  Removal/Repairs will be made as needed.	



F372

of maintenance by 8/3/12  
to identify other  
opportunities for  
improvement.  
Removal/Repairs will be  
made as needed.

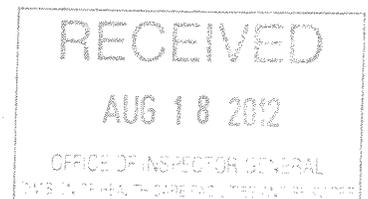
3. The maintenance  
staff will be re-educated  
by the administrator on  
8/3/12 on the

responsibility of the  
department to ensure and  
maintain the appropriate  
disposal of garbage and  
refuse on the property. A  
schedule has been  
developed for weekday  
rounds by the maintenance  
department of the exterior  
of the facility to provide  
the necessary clean up to  
ensure the proper disposal  
of garbage.

The maintenance director  
and the staff will be re-  
educated by the  
administrator on 8/3/12 on  
the use of the QA tool that  
will be used to identify the  
proper disposal of refuse  
on the facility grounds.

4. The QA tool will  
be used weekly x 4 weeks  
and then monthly. Results  
of the audit will be  
reviewed at the monthly  
QA meeting to ensure a  
safe, clean, comfortable  
homelike environment.

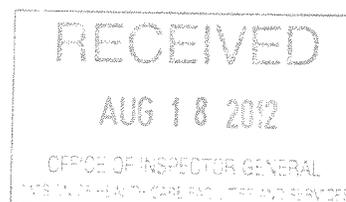
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F 441	Continued From page 13 to help prevent the development and transmission of-disease-and-infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 441	F441 1. Resident #6 Foley Catheter was discontinued on 7/19/12. Nursing Staff was re-educated by the ADCS on Infection Control related to foley catheter drainage bags.  Resident #4 – Licensed staff were re-educated by the ADCS on 7/20/12 regarding infection control with regards to washing of hands and glove changes.  B Hall Shower Room – all containers of deodorant were thrown away and the facility assured that all current residents had deodorant available for their use.  2. Resident with orders for treatments/wound care, skin assessments and foley catheters had the potential to be affected by this practice.  Residents with need for and/or use of deodorant had the potential to be affected.		



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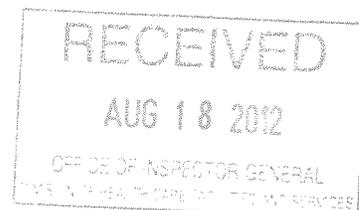
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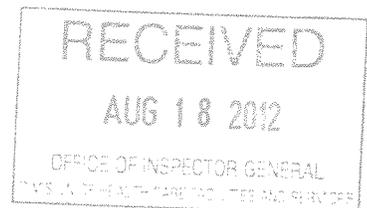
F 441	<p>Continued From page 14</p> <p>the facility's policies, it was determined the facility failed to maintain an infection control program to ensure a safe, sanitary, and clean environment for the prevention and transmission of disease. The facility staff failed to ensure a urinary catheter bag was not laying on the floor for one (1) of eighteen (18) residents, Resident #6, two (2) nurses failed to perform proper hand hygiene and glove changes during skin assessments and wound care for three (3) of eighteen (18) sampled residents, Residents #4, #6, and #7 and the facility staff failed to identify which resident utilized the five (5) containers of underarm deodorant in the B Hall shower room.</p> <p>The findings include:</p> <p>Review of the facility's hand washing policy titled IC-295, Hand Washing Technique, dated 03/12, revealed hands must be washed before a clean procedure, after contact with contaminated items or surfaces, and after removal of gloves.</p> <p>Review of the facility's policy for disposable glove use, titled IC-280, Gloves, Disposable Non-Sterile, dated 03/12, revealed glove removal, hand washing, and application of clean gloves would occur between residents and between different body site procedures performed subsequently on the same resident.</p> <p>Review of the facility's policy for dressing changes, titled N-1310, Specialized Needs-Aseptic Dressing Change, dated 03/12, revealed disposable gloves would be worn to remove and dispose of a soiled dressing, soiled gloves would be removed, hands would be washed, and clean gloves would be applied</p>	F 441	<p>During the survey Resident #6 was the only resident with a foley catheter. At present there are no residents with foley catheters.</p> <p>Upon review of Residents #6's chart and labs over the past 90 days it was noted that the resident has not had any s/s of infection and all labs are WNL. The last urinalysis on this resident was 2/21/12 and it was negative.</p> <p>Upon review of Infection Control Tracking/Trending Reports is was noted that the facilities current infection control rates for: 07/2012 = 0.7% 06/2012 = 1.48% 05/2012 = 1.8%</p> <p>The second shower room (C Hall) was checked on 7/13/12 any unlabeled items were discarded and the facility ensured that all current residents had needed products available.</p>	
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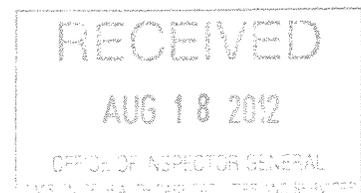
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F 441	<p>Continued From page 15</p> <p>before proceeding with treatment and redressing of the wound. Soiled gloves should be removed and hands should be washed at the completion of the dressing change.</p> <p>Interview with the Unit Manager, on 07/12/12 at 5:10 PM, revealed it was the facility's policy to wash hands before and after glove changes. Gloves should be changed after removing old dressings and putting a new dressing on, with hands washed in between. Not doing so placed the resident and other staff at risk of spreading infections.</p> <p>Interview, on 07/12/12 at 2:05 PM, with Registered Nurse (RN) #1, revealed hands should be washed every time gloves are removed with no exception to that rule, and hand washing and glove changes should occur after touching potentially contaminated surfaces or touching a resident's perineal area with a gloved hand.</p> <p>1. Observation, on 07/11/12 at 9:45 AM, revealed the catheter bag attached to Resident #6's indwelling catheter was laying on the floor at the bedside while Resident #6 was abed. Two additional observations, on 07/11/12 at 10:30 AM and on 07/11/12 at 11:45 AM, revealed the catheter bag attached to Resident #6's catheter tubing remained on the floor at his/her bedside.</p> <p>Interview, on 07/12/12 at 2:05 PM, with Registered Nurse (RN) #1, revealed catheter bags should be kept off the floor at all times.</p> <p>Interview, on 07/12/12 at 2:10 PM, with the Director of Nursing (DON) revealed catheter bags should never be left on the floor. The DON stated</p>	F 441	<p>Upon review of Infection Control Tracking/Trending Reports it was noted that over the past 120 days the facility had had 0% in-house acquired skin infections.</p> <p>3. Licensed nursing staff that complete dressing changes will be re-educated by the ADCS by 8/10/12 on the following topics:</p> <ul style="list-style-type: none"> <li>• Infection Control Policy and Procedures</li> <li>• Infection Control during wound/treatment procedures</li> <li>• Infection Control regarding foley catheters and drainage bags</li> <li>• Gloves, Disposable Non-Sterile Policy and Procedures</li> <li>• Infection Control Guidelines with regards to personal care items/toiletries.</li> </ul>		



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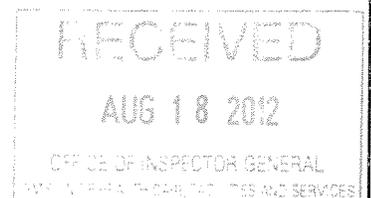
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NAME OF PROVIDER OR SUPPLIER  <b>BROWNSBORO HILLS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2141 SYCAMORE AVENUE LOUISVILLE, KY 40208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 16 she took catheter bags laying on the floor very seriously as she was very proud of the facility's low infection rate.  2. Observation, on 07/11/12 at 9:45 AM, revealed Licensed Practical Nurse (LPN) #1 donned clean gloves, undressed Resident #6 for the skin assessment, and while doing so, she touched the soles of the resident's shoes with her gloved hands. LPN #1 did not remove her gloves, wash her hands, and don clean gloves before opening a 4 x 4 gauze which she touched while placing it into a cup of normal saline solution. The same saline saturated gauze was used by LPN #1 to cleanse the wound on Resident #6's right buttock. In addition, during the skin assessment, LPN #1 separated Resident #6's labial folds with her gloved hands and did not remove her gloves wash her hands and don clean gloves but continued the skin assessment touching Resident #6's legs and feet after contact with the resident's perineal area.  3. Observation of the skin assessment performed on Res #7, on 07/11/12 at 10:00 AM, revealed LPN #1 assessed the resident's arms, back, stomach and the resident's peri area. LPN #1 then removed her gloves and placed new gloves on and assessed the remaining lower extremity body parts, which were his/her legs, shins and feet. LPN #1 was observed to not wash her hands between glove change.  4. Observation of the D hall shower room, on 07/12/12 at 2:45 PM, revealed a wall cabinet contained two (2) bottles of Brut roll on deodorant, two (2) bottles of Secret deodorant, and one (1) bottle of Fresh Scent roll on	F 441	Unit Manager will perform random 10% resident audit of skin assessments on each unit (utilizing QA Audit Tool) weekly x 4 weeks, then monthly x 3 months, then quarterly; to visually see that Licensed Nurses are washing their hands and changing gloves during skin assessments.  The DCS will check 100% of community shower rooms weekly x four weeks, monthly x 3 months, then quarterly to assure toiletries/personal care items are properly labeled and stored.  The ADCS will perform random 10% audit of dressing changes/wound care on each unit (utilizing QA audit tool) weekly x 4 weeks, monthly X 3 months, then quarterly to visually see that Licensed Nurses are washing their hands and changing gloves while performing wound care.		



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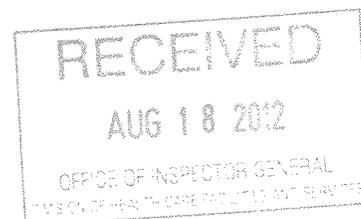
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F 441	Continued From page 17 deodorant. None of the bottles were labeled with a resident's name.  Interview with Certified Nursing Assistant (CNA) #2, on 07/12/12 at 2:50 PM, revealed the deodorant in the cabinet was used on residents. The CNA revealed the deodorant should have name's on the bottles to denote owner and prevent it from being used on other residents. The CNA revealed a potential problem with infection control.  5. Observation of a dressing change for Resident #4's Stage IV with LPN #2, on 07/12/12 at 10:55 AM, revealed the LPN assembled supplies and did not wash her hands. She donned gloves and removed all splints, turned the feeding tube pump to off, closed the blinds and curtains, adjusted the bed, placed the splints in the chair, then removed the resident's dressing to the Gtube site and placed it in the trash. The LPN removed the gloves and placed new gloves on. The LPN cleaned the wound, applied a new dressing and dated it with a marker using the same gloves. She then moved to the sacrum wound dressing without changing the gloves. The LPN opened the 4x4s poured Betadine on the 4x4s, used the same marker to date the ABD pad and then placed the marker in her pocket. She then poured a cup of normal saline into the wound and patted dry with a 4x4 pad using the same gloves. The wound tunneled at 12 o'clock the full length of the Qtip. The LPN then packed the wound with 2 opened 4x4s and covered the wound with the ABD pad. The resident's brief was adjusted and	F 441	The charge nurses will perform 100% audit of all residents with foley catheters 2x/day, 5x/week X 4 weeks (utilizing QA audit tool), then monthly X 3 months, then quarterly to assure that resident's with foley catheters have tubing and bags appropriately placed with regards to infection control.  Audit tools will be developed and implemented by 8/13/12. Any noted areas of concern will be immediately addressed and reported to the DCS per Unit Manager/ADCS. The audits will be reviewed weekly during Morning Meeting to further discuss and address any identified issues and/or continued educational needs of the staff.	



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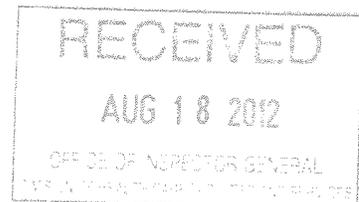
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F 441	Continued From page 18 re-secured. The resident's position, gown and bed were readjusted. A pillow was placed between the resident's legs, Gtube was adjusted, the bed crank was touched and the Gtube restarted, all while wearing the same pair of gloves. The LPN then took a wash cloth to the bathroom, removed her gloves, put on new gloves, wet the wash cloth to wash the resident's face.  Interview with LPN #2, on 07/12/12 at 4:00 PM, revealed she had inservices last year regarding wounds, different types of wounds, and the policy. She had not received training on dressing changes. She stated it was nursing practice to use clean dressings on a wound. She indicated staff should wash their hands before leaving a room or going into a room, or sanitize the hands. She stated she did not think she had to change her gloves after removing a dirty dressing. The LPN continued to say she did not remove her soiled gloves and place new ones on with the resident's dressing change and she did not wash her hands after the Gtube and sacrum dressing changes. She indicated her actions posed a risk of spreading infection to others and to the resident, especially since the resident was fragile and compromised.  Interview with LPN #3, on 07/12/12 at 3:19 PM, revealed she was taught to wash hands between glove changes. LPN #3 stated they wash their hands because they move from a dirty to clean surface. LPN #3 stated they wash their hands to prevent the spread of germs and introducing anything new to the resident.	F 441	4. Infection Control Audits will be reviewed in the monthly QA meeting until 100% compliance is achieved X 3 months, then quarterly to ensure facility maintains an infection control program to ensure a safe, sanitary, and clean environment for the prevention and transmission of disease.	F441 8/24/12	



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F 441	Continued From page 19	F 441			
	<p>Continued interview with the Unit Manager, on 07/12/12 at 5:10 PM, revealed observations made with LPN #2 should not have happened as gloves for dressing changes are one time use.</p> <p>Continued interview, on 07/12/12 at 2:05 PM, with Registered Nurse (RN) #1, revealed the potential problem with not performing hand hygiene and changing gloves after touching contaminated surfaces, and potentially contaminated areas of the body would be the spread of infection to the resident, to other residents, and to other staff members. RN #1 stated the Assistant Director of Nursing (ADON) was responsible for infection control education for new employees.</p> <p>Interview with the ADON, on 07/12/12 at 5:25 PM, revealed the education provided to the nurses is basic and reviewed in one day. It included wound care. It is hers and the DON's responsibility to educate the nurses regarding wound care. In addition, she stated there was a policy and procedure manual for the staff to utilize at the nurse's station. The ADON went on to say the dressing changes with one set of gloves and no hand washing, touching items on the bed, pump and Gtube was an issue. The actions of the LPN placed the resident, employees and visitors at risk for spread of infections through cross contamination. This is not a standard of practice.</p> <p>Continued interview, on 07/12/12 at 2:10 PM, with the Director of Nursing (DON) revealed employee in-services for hand washing occurred at least annually, and more often as needed. In-services</p>				



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F 441	Continued From page 20 on wound care, dressing changes, and infection control as it applied to skin care, occurred within the past two (2) months. The DON stated the facility had a Quality Assurance (QA) program, and QA occurred monthly with emphasis on various resident care-related areas. The DON stated she was responsible for assuring the staff met annual competencies related to infection control practices, and she, along with the ADON, and the Unit Manager monitored direct care givers for proper hand washing technique, wound care, and glove use through periodic on-unit observations.	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962, 1983, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/11/12. Brownsboro Hills Nursing Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jan Stahl* ADMINISTRATOR X 8/18/12 TITLE \_\_\_\_\_ (X6) DATE

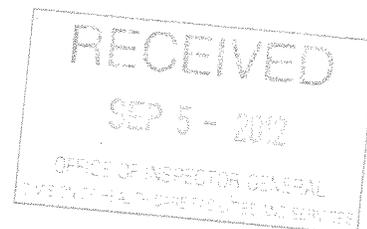
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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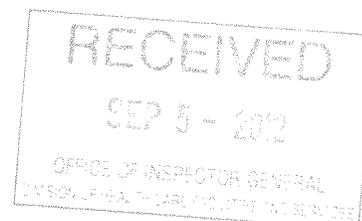
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K 000	Continued From page 1	K 000			
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a</p>	K 018	<p>Brownsboro Hills Health Care acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and plan of correction does not constitute any admission that any deficiencies are accurate. The plan of correction is submitted as a written allegation of compliance.</p> <p>K018 – It is the policy of this facility to be in compliance with this regulation.</p> <p>1. Room E-6 – the door jams have been repaired to ensure the resistance of the passage of smoke.</p> <p>Doors on rooms A-2, A-6 and A-8 have been repaired to ensure closure/latching and the resistance of the passage of smoke.</p>		



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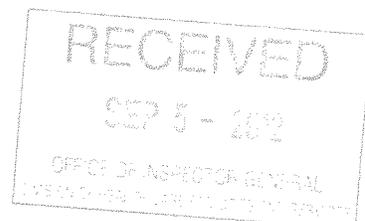
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K 018	<p>Continued From page 2</p> <p>census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed the corridor doors to room E-6 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interview, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed he was not aware of the doors having a gap that would not resist the passage of smoke.</p> <p>Observation, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed the corridor doors to room A-2, A-6, and A-8 would not latch when closed. The doors would not resist the passage of smoke.</p> <p>Interview, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed he was not aware the doors would not latch.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be</p>	K 018	<p>2. An audit of all smoke resistant doors to be completed by 8/10/12 by Maintenance for appropriate closure to ensure the resistance of smoke. Corrections will be made based on findings.</p> <p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to smoke resistance and the on the use of the QA audit tool to be used to monitor for proper closure of smoke resistant doors.</p> <p>4. Audits will be conducted weekly x 4 weeks then monthly. Audit results and any corrective action will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 018 8/24/12	



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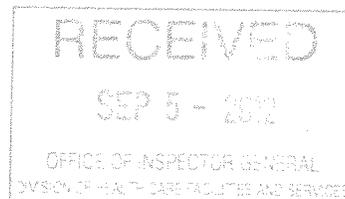
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K 018	Continued From page 3 substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may	K 025			



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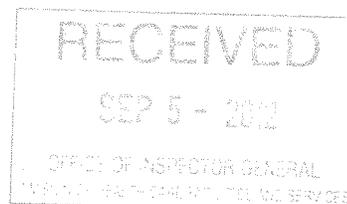
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K 025	<p>Continued From page 4</p> <p>terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 07/11/12 between 8:30 AM and 11:00 AM, with the Maintenance Director revealed the smoke partitions, extending above the ceiling had multiple penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Further observation revealed the fire wall located at the Pedway did not extend all the way up to the roof.</p> <p>Interview, on 07/11/12 between 8:30 AM and</p>	K 025	<p>K025- It is the policy of this facility to be in compliance with this regulation.</p> <ol style="list-style-type: none"> <li>1. Penetrations of the smoke barriers above the ceiling have been repaired. The firewall located at the Pedway has been repaired to extend all the way up to the roof.</li> <li>2. Maintenance will complete an audit of all smoke barriers to ensure no further penetration exits by 8/10/12. Repairs will be made as necessary. Based on findings, maintenance will complete an audit of fire walls to ensure all fire walls extend all the way up to roof deck.</li> <li>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to smoke barriers</li> </ol>		



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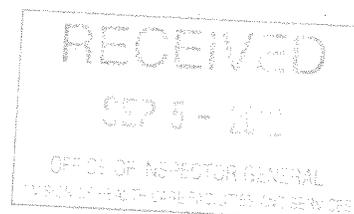
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  07/11/2012
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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K 025	Continued From page 5 11:00 AM, with the Maintenance Director revealed he was not aware of the penetrations. Further interview revealed he was not aware the fire wall did not extend up to the roof.  Reference: NFPA 101 (2000 Edition).  8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	and the on the use of the QA audit tool to be used to monitor for penetrations in smoke barriers.  4. Audits will be conducted weekly x 4 weeks then monthly. Audit results and any corrective action will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.	K 025  8/24/12	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated	K 027			



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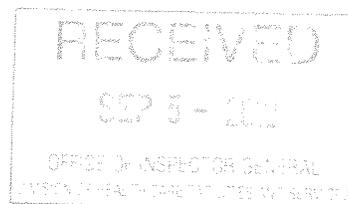
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K 027	<p>Continued From page 6</p> <p>protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed the cross-corridor doors located throughout the facility would not close completely when tested. This was due to the doors not having a coordinating device to ensure the door without the t-astagal would close first after the initial close.</p> <p>Interview, on 07/11/12 between 11:00 AM and 3:40 AM, with the Maintenance Director revealed he was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p>	K 027	<p>K027 - It is the policy of this facility to be in compliance with this regulation.</p> <ol style="list-style-type: none"> <li>Coordinating devices will be attached to all cross-corridor doors by 8/20/12.</li> <li>All cross-corridor doors are potentially affected and will be audited and repaired as indicated.</li> <li>The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to cross-corridor doors closure and the on the use of the QA audit tool to be used to monitor for adequate closure.</li> </ol>		



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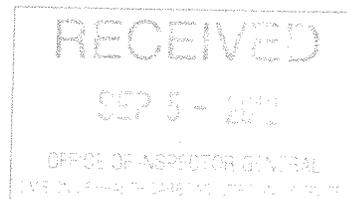
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K 027	Continued From page 7  NFFA Standard: NFFA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFFA 80 (1999 Edition)  2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.  Reference: NFFA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	4. Audits will be conducted weekly x 4 weeks then monthly. Audit results and any corrective action will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.  K029 - It is the policy of this facility to be in compliance with this regulation.  1. The door into the medical records office has been repaired and door completely closes.	K 027  8/24/12
K 029 SS=D	NFFA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	2. An audit of all smoke resistant doors will be completed by 8/10/12 by Maintenance for appropriate closure to ensure the resistance of smoke. Corrections will be made as needed.	



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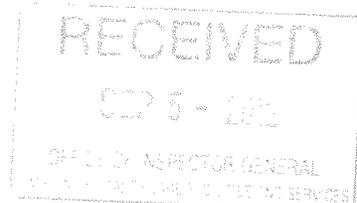
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K 029	<p>Continued From page 8</p> <p>field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/11/12 at 2:38 PM, with the Maintenance Director revealed the door to the Medical Records room was equipped with a small door self-closing device, however the device was not suitable for keeping the door closed and would leave the door ajar.</p> <p>Interview, on 07/11/12 at 2:38 PM, with the Maintenance Director revealed he was not aware the door would not close completely with the self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 029	<p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to smoke resistance and the on the use of the QA audit tool to be used to monitor for proper closure of doors.</p> <p>4. Audits will be conducted weekly x 4 weeks then monthly. Audit results and any corrective action will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 029 8/24/12



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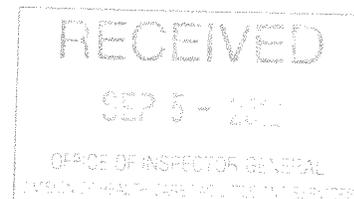
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K 029	Continued From page 9 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		



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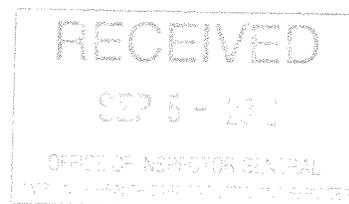
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K 038	Continued From page 10 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, and laundry staff. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey. The findings include:  Observation, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed the two (2) exits from the laundry room did not have a durable surface to a public way.  Interview, on 7/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed they were not aware the exits needed a durable surface to the public way.  Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1.  Reference: NFPA 101 (2000 edition)	K 038	K038 - It is the policy of this facility to be in compliance with this regulation.  1. Sidewalks will be installed by 8/23/12 leading from the two (2) laundry exits to the public way.  2. The maintenance director has completed an audit of all exterior exit areas to ensure a safe passage is available.  3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to exit access standards and the on the use of the QA audit tool to be used to monitor for maintained egress in case of fire.  4. Audits will be conducted weekly x 4	



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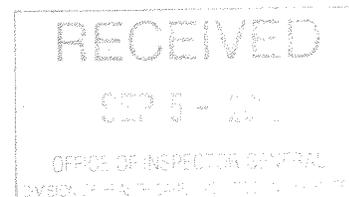
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K 038	Continued From page 11 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038	weeks then monthly. Audit results and any corrective action will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.	K 038 8/24/12
K 045 SS=D	CMS S&C letter 5-38 NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	K045 - It is the policy of this facility to be in compliance with this regulation.  1. The exit light bulb was replaced on the A wing. Exit off the dining room will be equipped with lighting to meet NFPA requirements. Exits lights will be installed on the two laundry room exits by 8/23/12.	



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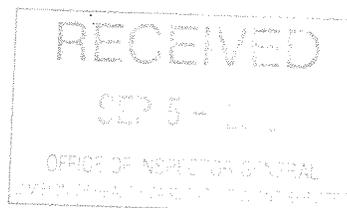
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K 045	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed the exterior exit in the A Wing only had one light bulb, also the exit off the dining room, and the two (2) exits off the basement laundry room did not have a light fixture outside to light the egress path.</p> <p>Interview, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed he was not aware the lighting fixtures serving the exterior exits must include more than one bulb.</p> <p>Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness.</p> <p>Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p>	K 045	<p>2. The maintenance director has completed an audit of all exterior exit areas to ensure exits are equipped with lighting in acceptance with NFPA requirements. Corrections made as necessary.</p> <p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to exit lighting and the use of the QA audit tool to be used to monitor for adequate exit lighting.</p> <p>4. Audits will be conducted weekly x 4 weeks then monthly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 045  8/24/12	



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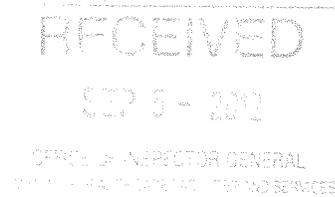
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K 046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation and record review, on 07/11/12 at 8:10 AM, with the Maintenance Director revealed that the emergency lights, with battery backup, located throughout the facility were not tested for 1-1/2 hours within the last year.</p> <p>Interview, on 07/11/12 at 8:10 AM, with the Maintenance Director revealed he was aware the lighting had to be tested annually for 1-1/2 hours.</p> <p>Observation, on 07/11/12 at 12:26 PM, with the Maintenance Director revealed an emergency light located in the Front Lobby, did not function when tested.</p> <p>Interview, on 07/11/12 at 12:26 PM, with the Maintenance Director revealed he was unaware the light was not functioning properly.</p>	K 046	<p>K046 - It is the policy of this facility to be in compliance with this regulation.</p> <ol style="list-style-type: none"> <li>The emergency lights with battery backup have been tested for the 1 ½ hours and documented. The emergency light located in the front lobby has been repaired.</li> <li>The maintenance director has completed an audit of all emergency lights to ensure appropriate lighting. Corrections made as necessary, and documented.</li> <li>The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to exit lighting and testing and the on the use of the QA audit tool to be used to monitor for adequate exit lighting.</li> </ol>		



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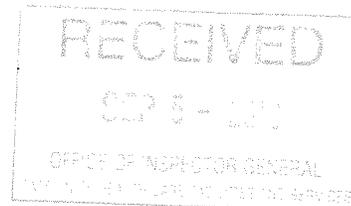
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K 046	Continued From page 14  Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	4. Audits will be conducted weekly x 4 weeks then monthly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.  K050 - It is the policy of this facility to be in compliance with this regulation.  1. Fire drills were conducted on the following dates: 10/25/11 4:00 am, 3 <sup>rd</sup> shift, 11/28/11 9:00 am, 1 <sup>st</sup> shift, 12/16/11 3:00 pm, 2 <sup>nd</sup> shift, 4/11/12 1 <sup>st</sup> shift, 5/7/12 2 <sup>nd</sup> shift, 6/5/12 3 <sup>rd</sup> shift.  2. There is a potential for all residents to be affected.	K 046 8/24/12	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050			



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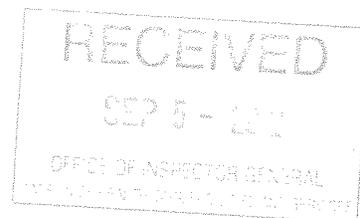
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K 050 SS=F	<p>Continued From page 15</p> <p>Fira drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 07/11/12 at 8:05 AM, with the Maintenance Director revealed the facility did not have complete fire drill records. Only three (3) fire drill records, one (1) for each of the three (3) shifts, could be produced at the time of the survey. A fire drill was performed on 06/05/12 for first shift, on 05/07/12 for second shift, and 04/11/12 for third shift.</p> <p>Interview, on 07/11/12 at 8:05 AM, with the</p>	K 050	<p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to fire drill standards.</p> <p>4. Administrator will audit for fire drill being conducted per standards. Results of the monthly fire drills will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 050 8/24/12	



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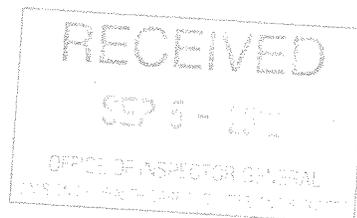
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K 050	Continued From page 16 Maintenance Director revealed he had just started working at the facility in April and he could find no fire drill records from before his hire date.  interview, on 07/11/12 at 4:30 PM, with the Administrator revealed she was confident fire drills were being conducted prior to the hiring of the new Maintenance Director in April of 2012, however she was not aware of the location of the fire drill records, that had been in the care of the previous Maintenance Director, to prove they had been conducting fire drills as required.	K 050			
K 056 SS=D	Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by:	K 056	K056 - It is the policy of this facility to be in compliance with this regulation.  1. The two porches in the courtyard will have adequate sprinkler protection by 8/23/12.  2. Review conducted throughout facility to ensure sprinkler protection is in place per NFPA standards.		



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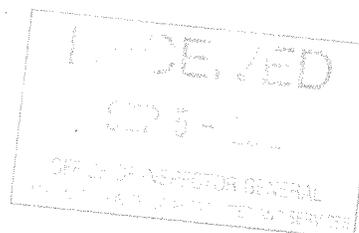
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K 056	<p>Continued From page 17</p> <p>Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 7/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed two (2) porches in the courtyard area, used for a smoking area. The porches were over four (4) feet in width, and made of combustible material, and not sprinkler protected. The porches are the result of the building being in a triangle shape, and the overhangs join in such a way they create the porch roofs.</p> <p>Interview, on 7/11/12 between 8:00 AM and 3:40 PM, with the Director of Maintenance revealed they were not aware the porches were required to be sprinkler protected.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Reference: NFPA 13 (1999 Edition) 5-13 8.1</p>	K 056	<p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to fire sprinkler systems and requirements of the system and the on the use of the QA audit tool to be used to monitor for an appropriately maintained sprinkler system.</p> <p>4. Audits will be conducted monthly x 3 months and then quarterly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 056 8/24/12



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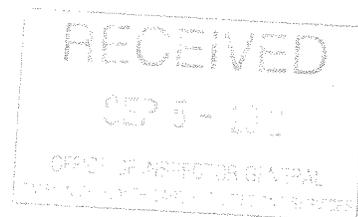
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K 056	Continued From page 18  Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility	K 062	K062 - It is the policy of this facility to be in compliance with this regulation.  1. An inspection of the fire sprinkler system including an internal pipe inspection will be completed by 8/23/12. The gauges on the sprinkler riser will be calibrated or replaced by 8/23/12. The sprinkler heads in the attic will be cleared of insulation by 8/23/12. The sprinkler heads in therapy have been cleaned of excessive lint. Sprinkler heads with paint will be replaced by 8/23/12.	



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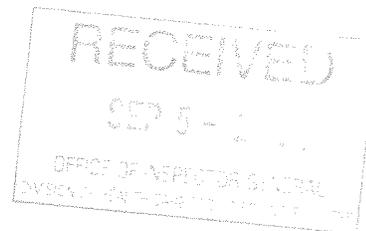
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K 062	<p>Continued From page 19</p> <p>failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 07/11/12 at 8:00 AM, with the Maintenance Director revealed the facility did not have documentation for the fourth quarter inspection of the fire sprinkler system for 2011. Components located in the fire sprinkler system must be inspected monthly and quarterly accordingly to NFPA requirements and the records for the inspection made available for the authority having jurisdiction.</p> <p>Interview, on 7/11/12 at 8:00 AM, with the Maintenance Director revealed he was unaware the fourth quarter inspection of the sprinkler system had been missed.</p> <p>Sprinkler testing record review, on 07/11/12 at 8:00 AM, with the Maintenance Director revealed the sprinkler system had no internal pipe inspection within the last 5 years. The last noted internal pipe inspection was in 2004.</p> <p>Interview, on 07/11/12 at 8:00 AM, with the Maintenance Director revealed he was unaware the sprinkler system had not had an interior pipe inspection since 2004.</p> <p>Sprinkler testing record review, on 7/11/12 at 8:00</p>	K 062	<p>2. There is a potential for all residents to be affected.</p> <p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to fire sprinkler systems and requirements of the system and the on the use of the QA audit tool to be used to monitor for an appropriately maintained sprinkler system.</p> <p>4. Audits will be conducted monthly x 3 months and then quarterly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 062 8/24/12



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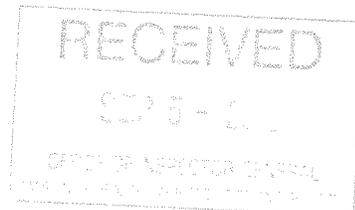
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K 062	<p>Continued From page 20</p> <p>AM, with the Maintenance Director revealed the facility did not provide documentation that the gauges on the sprinkler riser had been calibrated within the last 5 years.</p> <p>Interview, on 7/11/12 at 8:00 AM, with the Maintenance Director revealed he was not aware the gauges on the sprinkler riser had to be calibrated once every 5 years.</p> <p>Observation, on 7/11/12 between 8:00 AM and 11:00 AM, with the Maintenance Director revealed the sprinklers in the attic were blocked by fiberglass insulation that had blown around the attic and attached itself to the heads.</p> <p>Interview, on 7/11/12 between 8:00 AM and 11:00 AM, with the Maintenance Director revealed he was unaware the insulation had blown around and attached itself to the sprinkler heads, blocking the spray pattern of the sprinkler heads.</p> <p>Observation, on 07/11/12 at 11:14 AM, with the Maintenance Director revealed excessive buildup of lint on the sprinkler heads located in the Therapy Charting Room.</p> <p>Interview, on 07/11/12 at 11:14 AM, with the Maintenance Director revealed he was not aware of the lint buildup on the sprinkler heads.</p> <p>Observations, on 07/11/12 between 8:00 AM and 3:40 PM, with the Maintenance Director revealed paint, or corrosion on most all of the sprinkler heads throughout the facility, including the outside. The only area the sprinkler heads were noted to be paint free was in the Therapy Room.</p>	K 062			



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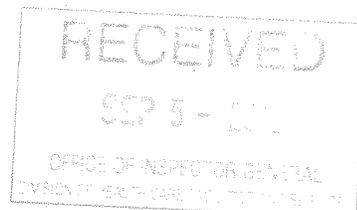
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K 062	<p>Continued From page 21</p> <p>Interview, on 07/11/12 between 8:00 AM and 3:40 PM, with the Maintenance Director revealed he was not aware of the corrosion, and that so many sprinkler heads had been painted.</p> <p>Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers</p>	K 062			



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K 062	<p>Continued From page 22 are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p>	K 062			



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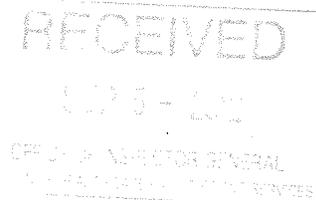
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K 062	Continued From page 23 Reference: NFPA 25 (1998 Edition).  2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1	K 062			



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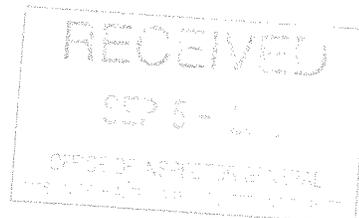
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K 062	Continued From page 24 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds and the census was eighty nine (89) on the day of the survey.  The findings include:	K 064	K064 - It is the policy of this facility to be in compliance with this regulation.  1. Signage stating that the hood suppression system must be used before the class K fire extinguisher has been posted. The portable class K extinguisher located in the kitchen will be remounted to meet guidelines by 8/23/12.  2. Review of fire extinguishers to ensure standard is met.  3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to the placement	



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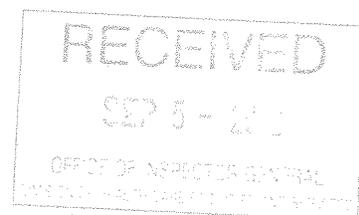
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K 064	<p>Continued From page 25</p> <p>Observation, on 07/11/12 at 12:03 PM, with the Maintenance Director revealed there was no signage stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>Interview, on 07/11/12 at 12:03 PM, with the Maintenance Director revealed he was unaware of the signage requirement.</p> <p>Observation, on 07/11/12 at 12:03 PM, revealed the wall mounted, portable K Class, fire extinguisher located in the Kitchen was mounted above the maximum allowable height of five (5) feet above the finish floor.</p> <p>Interview, on 07/11/12 at 12:03 PM, with the Maintenance Director, revealed that he was not aware of the height limitations for wall mounted portable fire extinguishers and acknowledged that the K Class extinguisher in the Kitchen was mounted above the height of five (5) feet above the finish floor.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>Reference NFPA 10 (1998 Edition).</p> <p>1-6.10 Fire extinguishers having a gross weight</p>	K 064	<p>of portable fire extinguishers and the on the use of the QA audit tool to be used to monitor for the placement of hood suppression signage and the mounting of portable extinguishers. Dietary staff will be re-educated by the Maitnenance Director on the proper use of the kitchen fire suppression.</p> <p>4. Audits will be conducted monthly x 3 months and then quarterly. Audit results and any corrective measures will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 064 8/24/12



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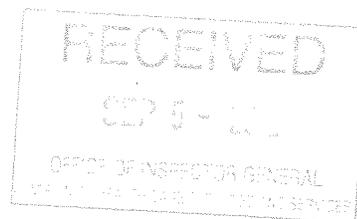
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K 064	Continued From page 26 not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	K072 - It is the policy of this facility to be in compliance with this regulation.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.  The findings include:  Observation, on 07/11/12 between 8:00 AM and 3:40 PM, with the Maintenance Director revealed a table stored in the egress path to the exit in the	K 072	1. The table in the therapy room was relocated within the gym. The vending machine, wheelchair and cart were removed from the service hall. Med Carts on D Hall stored as to not block egress.  2. The maintenance director has completed an audit of all means of egress to ensure no obstruction in case of an emergency. Corrections will be made as necessary.  3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to means of egress and the on the use of the	



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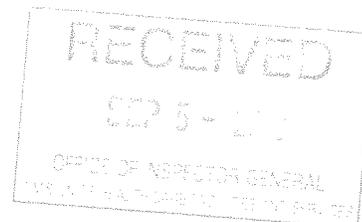
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K 072	Continued From page 27 Therapy Room, also a vending machine, wheelchair, and a cart stored in the exit corridor by the Kitchen. Further observation revealed the storage of med carts in the D Hall next to the Lobby.  Interview, on 07/11/12 between 8:00 AM and 3:40 PM, with the Maintenance Director revealed the facility routinely stored items in these areas.  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	QA audit tool to be used to means of egress. All staff will be in serviced by the maintenance director on the need to ensure an uncluttered means of egress on 8/17/12.		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 076	4. Audits will be conducted weekly x 4 weeks then monthly. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.  K 076 - It is the policy of this facility to be in compliance with this regulation.  1. Additional signage was placed on the outside door of the oxygen storage room.	K 072	8/24/12



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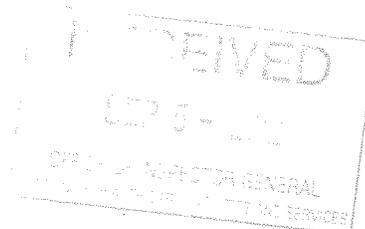
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K 076	<p>Continued From page 28</p> <p>determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/11/12 at 11:50 AM, with the Maintenance Director revealed the facility failed to provide proper signage stating oxygen was stored inside the oxygen storage room located in C-Hall.</p> <p>Interview, on 07/11/12 at 11:50 AM, with the Maintenance Director revealed he was not aware the oxygen storage room was required to have proper signage on the outside of the door.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft)</p>	K 076	<p>2. Facility was audited throughout for safe storage of oxygen. Appropriate follow-up based on findings.</p> <p>3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to required signage for oxygen storage and the on the use of the QA audit tool to be used to monitor for the appropriate signage for oxygen storage.</p> <p>4. Audit will be conducted monthly x 3 months and then quarterly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.</p>	K 076	8/24/12



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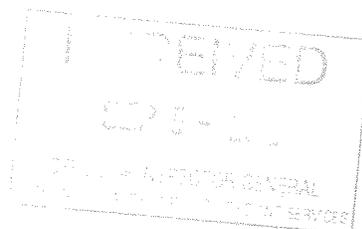
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K 076	Continued From page 29 (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076			
K 130 SS=D	8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.	K 130	K 130 - It is the policy of this facility to be in compliance with this regulation.  1. The bottom of all dryers were cleaned of lint. The helium tank in the activities office was secured to a wall stud.  2. Audit of all dryers conducted to ensure they were being maintained free of lint.		



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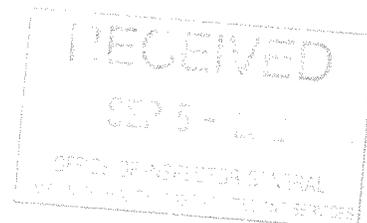
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K 130	Continued From page 30 The findings include:  Observation, on 07/11/12 at 3:06 PM, with the Maintenance Director revealed a heavy buildup of lint in the bottom of the dryers, in the Laundry Room.  Interview, on 07/11/12 at 3:06 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive.  Observation, on 07/11/12 at 3:21 PM, with the Maintenance Director revealed the helium tank located in the Activities Office was not secured properly to prevent the tank from falling over. A chain was around the tank and fastened to the wall with a screw; however the screw was not in a wall stud and fell out of the drywall when inspected.  Interview, on 07/11/12 at 3:21 PM, with the Maintenance Director revealed he was not aware the tank was not secured properly.	K 130	3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to cleaning of lint in the dryer and securing helium tanks and the on the use of the QA audit tool to be used to monitor for lint in the dryer and the safe storage of the helium.  4. Audits will be conducted monthly x 3 months and then quarterly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.		
K 144 SS=F	Reference: NFPA 101 (2000 Edition) NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		K 130	8/24/12



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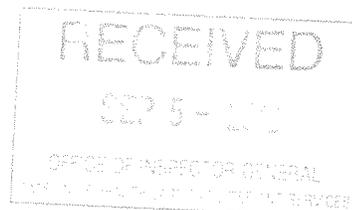
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K 144	Continued From page 31  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.  The findings include:  Observation, on 07/11/12 at 12:14 PM, with the Maintenance Director revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increased risk of fire.  Interview, on 07/11/12 at 12:14 PM, with the Maintenance Director revealed they were not aware that the battery charger could not be hooked directly to the battery.  Reference: NFPA 110 (1999 Edition).  5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices.	K 144	K 144 - It is the policy of this facility to be in compliance with this regulation.  1. The generator's battery charger is no longer hooked directly to the battery.  2. All residents are potentially affected.  3. The maintenance department will be re-educated by the administrator by 8/10/12 on the life safety codes related to the generator's battery charger and the on the use of the QA audit tool to be used to monitor the generator's battery connections.  4. Audits will be conducted monthly x 3 months and then quarterly. Audit results and any corrective action will be documented.	



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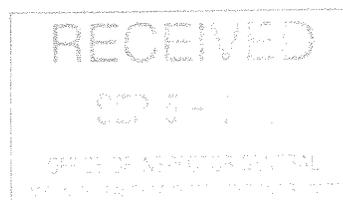
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K 144	Continued From page 32 Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144	Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.  K 147 - It is the policy of this facility to be in compliance with this regulation.  1. The cord to the air conditioning unit in the unit manager's office and social services office are directly plugged into the receptacle. The extension cord has been removed from the human resources office. The second power strip was removed from the business office. The mini nebulizer was plugged directly into the receptacle. The refrigerator in the	K 144
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety six (96) beds with a census of eighty nine (89) on the day of the survey.  The findings include:  Observations, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed:  1) The cord to an air conditioning unit was run through a wall to the plug in the Unit Manager's Office. 2) An air conditioning unit was plugged into a power strip located in the Social Services Office. 3) An extension cord was in use to a computer located in the Human Resources Office. 4) A power strip was plugged into another power strip located in the Business Office. 5) A mini nebulizer was plugged into a power	K 147		8/24/12



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K 147	Continued From page 33 strip located in room A-3. 6) A refrigerator was plugged into a power strip located in the Housekeeping Office. 7) A refrigerator was plugged into a power strip located in room E-5. 8) The wall receptacle was broken behind the bed, due to the bed hitting the plug, located in room E-5. 9) A refrigerator was plugged into a power strip located in room E-11. 10) An I.V. machine was plugged into a power strip located in room B-3.  Interview, on 07/11/12 between 11:00 AM and 3:40 PM, with the Maintenance Director revealed he was not aware of the misuse of power strips and extension cords.  Reference: NFPA 99 ( 1999 edition) 3-3.2.1.2 D  Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical	K 147	housekeeping office is plugged directly into the receptacle. The refrigerator in room E5 is plugged directly into the receptacle. The wall receptacle in room E5 has been repaired. The refrigerator in room E 11 is plugged directly into the receptacle. The IV pump in room B3 is plugged directly into the receptacle.  2. An audit has been conducted by the maintenance director of all resident rooms, common areas and offices to identify and further concerns the use of power strips and extension cord. Corrections have been made as necessary.  3. The maintenance department will be re-educated by the administrator by 8/10/12	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  07/11/2012
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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K 147	Continued From page 34 apparatus that are controlled by lock and key shall be considered accessible to qualified persons.  Reference: NFPA 70 (1999 edition) 370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	on the life safety codes related to the use of power strips and extension cords and the on the use of the QA audit tool to be used to monitor the use of power strips and extension cords connections. All staff will be in-serviced on 8/17/12 by the maintenance director on the need to ensure an uncluttered means of egress.  4. Audits will be conducted weekly x four weeks, monthly x 3 months and then quarterly. Audit results and any corrective actions will be documented. Results of the QA audits will be discussed at the monthly QA meeting and revisions/corrections made as necessary.	K 147 8/24/12	

